Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Sagadraca Care Home	**CHAPTER 100.1**
Address: **94-329 Kiokio Place, Waipahu, Hawaii 96797**	**Inspection Date: November 4, 2019 Annual**

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-9 Personnel, staffing and family requirements. (b) All individuals who either reside or provide care or services to residents in the Type I ARCH shall have documented evidence of an initial and annual tuberculosis clearance. **FINDINGS** Substitute Care Giver (SCG) #2 – No documented evidence of current annual tuberculosis clearance by a physician	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**	

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-100.1-15 Medications. (e) All medications and supplements, such as vitamins, minerals, and formulas, shall be made available as ordered by a physician or APRN. **FINDINGS** Resident #1 – Physician ordered "Acetaminophen 325mg PO, take 2 tabs PO q4 hours PRN, not to exceed 4 doses in 24 hours," "Colace 100mg cap, take 1 cap PO BID PRN," & " Systane lubricant eye drops, one drop to each eye PRN" on 6/18/2019. Medication order by physician, medication label and medication administration record (MAR) did not indicate an as needed (PRN) use for using PRN medications.	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**	

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Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____